SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
Company Tracking Number:	*TRANS APA401008T APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Trans APA401008T APPL	SERFF Tr Num: CMPL-125670265	State: ArkansasLH
TOI: L09I Individual Life - Flexible Premium Adjustable Life	SERFF Status: Closed	State Tr Num: 39123
Sub-TOI: L09I.001 Single Life	Co Tr Num: TRANS APA401008T APPL	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Nancy French	Disposition Date: 06/03/2008
	Date Submitted: 05/29/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Trans APA401008T APPL	Status of Filing in Domicile:
Project Number: Trans APA401008T APPL	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/03/2008	
State Status Changed: 06/03/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This filing is being submitted by Compliance Research Services, LLC on behalf of Transamerica Life Insurance Company (Transamerica). A letter of filing authorization is enclosed.

Please find enclosed the above-referenced forms for your review and approval. The forms are single and joint life applications, medical history and supplemental questionnaires for use in connection with Transamerica's individual term

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life, universal life and variable universal life policies.

The forms are in final printed format. Transamerica reserves the right to change the type style and paper size or to issue the forms in electronic format. The forms are new and do not replace any forms currently on file with your Department.

The enclosed applications are not intended to change the risk and will not result in changes in any rates or actuarial data previously approved.

All required forms and transmittals are included with this submission.

You may direct any questions or comments regarding this submission to me at 513-984-6050 or e-mail me at dsimon@crssolutionsgroup.com.

Company and Contact

Filing Contact Information

(This filing was made by a third party - complianceresearchservicesllc)

Nancy French, Product Manager	nfrench@crssolutionsgroup.com
10921 Reed Hartman Highway	(513) 984-6050 [Phone]
Cincinnati, OH 45242	(513) 984-7212[FAX]

Filing Company Information

Transamerica Life Insurance Company	CoCode: 86231	State of Domicile: Iowa
1400 Centerview Drive	Group Code: 468	Company Type:
Little Rock, AR 72211	Group Name:	State ID Number:
(513) 984-6050 ext. [Phone]	FEIN Number: 39-0989781	

Filing Fees

Fee Required?	Yes
Fee Amount:	$140.00
Retaliatory?	No

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
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Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Fee Explanation:

Per Company: No

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
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Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	$140.00	05/29/2008	20557968

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/03/2008	06/03/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Application Supplement, Residency and Travel Questionnaire	Form	Nancy French	05/29/2008	05/29/2008

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
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Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Disposition

Disposition Date: 06/03/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
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Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Readability Certification		Yes
Supporting Document	Filing Authorization		Yes
Supporting Document	Statement of Variables		Yes
Form	Individual Life Application for One Life		Yes
Form	Application Part 2, Medical and Paramedical Health History		Yes
Form	Application Part 2, Non-Med Health History		Yes
Form	Life Insurance Application for Two Lives		Yes
Form	Application Supplement, Aviation Questionnaire		Yes
Form	Application Supplement, Sports and Hazardous Activities Questionnaire		Yes
Form *(revised)*	Application Supplement, Residency and Travel Questionnaire		Yes
Form	Application Supplement, Residency and Travel Questionnaire		Yes

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
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Product Name:	*Trans APA401008T APPL*		
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Amendment Letter

Amendment Date:

Submitted Date: 05/29/2008

Comments:

Please note the readability for form MPQ161008T should read 55.7.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
MPQ161008T	Application/Enrollment Form	Application Supplement, Residency and Travel Questionnaire	Initial				56	MPQ161008T Standard.pdf

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
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Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Form Schedule

Lead Form Number: Form APA401008T

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	APA401008T	Application/ Enrollment Form	Individual Life Application for One Life	Initial		50	APA401008T Standard Filed Final.pdf
	MPM31008T	Application/ Enrollment Form	Application Part 2, Medical and Paramedical Health History	Initial		55	MPM31008T Standard.pdf
	MPN11008T	Application/ Enrollment Form	Application Part 2, Non-Med Health History	Initial		55	MPN11008T Standard.pdf
	APA411008T	Application/ Enrollment Form	Life Insurance Application for Two Lives	Initial		50	APA411008T Standard Final Filed.pdf
	MPQ21008T	Application/ Enrollment Form	Application Supplement, Aviation Questionnaire	Initial		56	MPQ21008T Standard.pdf
	MPQ151008T	Application/ Enrollment Form	Application Supplement, Sports and Hazardous Activities Questionnaire	Initial		51	MPQ151008T Standard.pdf
	MPQ161008T	Application/ Enrollment Form	Application Supplement, Residency and Travel Questionnaire	Initial		56	MPQ161008T Standard.pdf

TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

GA # _____

Individual Life Insurance Application For One Life Part 1

Proposed Insured: _____ _____
First Middle Last Suffix Mr./Mrs./Ms./Dr.

Birthdate: _____ Age _____ Birth Place: _____ Male ☐ Female ☐
Mo. Day Yr.

Soc. Sec. No.: _____ U.S. Citizen ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire

Employer: _____ _____
Area Code & Work Phone

Occupation: _____

Annual Income $ _____ Net Worth $ _____

Residence: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Area Code & Home Phone

Owner's Name: _____ Birthdate: _____
(If other than Proposed Insured) Mo. Day Yr.

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured: _____

Address: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Soc. Sec. or Tax No.

U.S. Citizen ☐ Yes ☐ No If no, VISA Type/Immigration Status: _____ E-mail: _____
(Not for Policy/Billing Notices)

Beneficiary's Name and Relationship to Proposed Insured: _____

_____

Address: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Date of Trust, if Applicable

1. Plan Applied For: _____ Kind Code: _____
2. Risk Classification: Preferred Plus/Select ☐ Preferred ☐ Standard Plus ☐ Standard ☐
   Extra Rating of ☐ _____ Other ☐ _____
3. Nicotine Classification: Nicotine ☐ Non-Nicotine ☐
4. Amount Applied For $ _____
5. Additional Benefits by Rider: ☐ Waiver of Premium/Waiver Provision ☐ Accident Indemnity $ _____ ☐ Other _____ $ _____
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Other _____
   ☐ PAC ☐ Direct Bill
7. Complete for Flexible Premium Plans:
   Required Premium Per Year (RAP) $ _____
   Planned Periodic Premium $ _____
   + Initial Lump Sum $ _____
   = Total Initial Premium $ _____
8. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? ☐ Yes ☐ No (APL will be in effect unless no is checked.)
9. Do you have any existing life insurance or annuities? If none, check this box ☐. If yes, please list the policies below.
   a. Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? Please indicate yes or no in the chart.

Type of Coverage (Personal / Business / Employer Provided / Group)	Company/Policy Number	Face Amount	Replacement?
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

   b. Total Accidental Death insurance inforce with all companies: $ _____

continued on next page

10. Is any application for life insurance pending with any other company? ☐ Yes ☐ No
If yes, give company name, amount applied for and total amount to be placed. _____

11. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? ☐Yes ☐ No If yes, give insurance company name, owner's name, and amount of insurance of each policy.

_____

12. Mail Additional Premium Notices To: _____

Address: _____
No. & Street City State Zip Country

Yes	No	**"You" means any person proposed to be insured.**
☐	☐	13. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
☐	☐	14. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
		15. Have you used nicotine at any time? Date Last Used
☐	☐	Cigarettes _____
☐	☐	Cigar/Pipe/Chewing Tobacco _____
☐	☐	Other _____
		16. Driver's License #: _____ State: _____
		In the past five years, have you been convicted of or pleaded guilty to:
☐	☐	a. Moving violations? If yes, give dates and type. _____
☐	☐	b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
☐	☐	c. Reckless driving? If yes, give dates. _____
☐	☐	17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
☐	☐	18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
☐	☐	19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
☐	☐	20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

Remarks: Give details for any questions answered yes

_____

_____

_____

_____

_____

_____

I, the Proposed Insured, and I, the Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. **I/we agree:** (1) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (2) except as otherwise provided in the conditional receipt, if issued, with the same Proposed Insured as on this application, any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured is in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

I/we understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to you under Section 101(j) of the Internal Revenue Code to the extent it exceeds the premiums and other considerations paid by you for the policy unless the written Notice and Consent is obtained **prior to policy issue** and certain other requirements of such section are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the MIB Group, Inc. and its members or affiliates, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; Human Immunodeficiency Virus (HIV) related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

I acknowledge receipt of the Notice of Disclosure of Information. **I understand** that if an investigative consumer report is ordered in connection with this application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report. I elect to be interviewed if an investigative consumer report is prepared. ☐ Yes ☐ No

PLEASE MAKE CHECKS PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE SPACE BLANK.

Amount paid with this Application $ _____ ☐ Check # _____ ☐ Credit Card (Complete Credit Card Order Confirmation Form)

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Owner (if other than Proposed Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner, give corporate title and full name of corporation below.

_____ X _____
Signature of Licensed Producer

_____

_____

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Life Insurance Company (the Company) may make a brief report to the MIB Group, Inc. (MIB) and its members or affiliates, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Notice to Persons Applying for Insurance: Federal law requires us to advise you that in connection with this application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation by your written request made within a reasonable time after receipt of this notice.

Notice of Insurance Information Practices: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499].

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $_____ for the life insurance application dated _____ , with _____ as the Proposed Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, $400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

X _____
Signature of Proposed Owner
If Proposed Owner is a Trust, the Trustee must sign as Owner.
Give full name and date of Trust below.

_____ , 20 _____
Date
If Proposed Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner. Give corporate title and full name of corporation below.

_____ _____

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499], Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

Submit this completed and signed original with the application and payment.

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____, the sum of $_____ for the life insurance application dated _____, with _____ as the Proposed Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, $400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at _____ on _____ ,20 _____ X _____

City, State | Date | Insurance Producer or other Company Authorized Rep

---

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499], Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

Leave this page with the proposed Owner if money is submitted with application

Proposed Owner

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

GA # _____

Application Part 2
Health History

☐ Paramedical ☐ Medical

File # _____

1. **Proposed Insured:** *(Print Full Name)*	2. **Date of Birth:** Month Day Year	3. **Social Security #**

4. **Name/Address/Phone of primary care physician:**

Name: _____ Address: _____

Phone: (_____) _____ City/St/Zip: _____

Date and reason for last visit: _____

Give complete details of all yes answers to questions 5 - 8, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, attach sheet(s) of paper - **signed, dated and witnessed.**

5. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**	**Yes**	**No**
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	☐	☐
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	☐	☐
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	☐	☐
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	☐	☐
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	☐	☐
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	☐	☐
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	☐	☐
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	☐	☐
i. Cancer, tumor, polyp or cyst?	☐	☐
j. Any physical deformity or amputation?	☐	☐
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	☐	☐
l. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test?	☐	☐

6.	**Yes**	**No**
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstacy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	☐	☐
b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	☐	☐

7. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:**	**Yes**	**No**
a. Consulted, been examined or been treated by any physician or practitioner?	☐	☐
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study?	☐	☐
c. Had observation or treatment at a clinic, hospital or other medical facility?	☐	☐
d. Had or been advised to have a surgical procedure?	☐	☐
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	☐	☐
f. Had any injury requiring treatment?	☐	☐

Details:

* D T 2 2 4 *

File # _____

8.	Yes	No
a. Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide?	☐	☐
b. Has your weight changed by more than 15 pounds in the past year?	☐	☐
c. Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?	☐	☐
d. Are you now pregnant?	☐	☐

9. **OTHER THAN THOSE ALREADY DISCLOSED, ARE YOU CURRENTLY TAKING ANY PRESCRIPTION, VITAMIN, SUPPLEMENT OR OVER-THE-COUNTER MEDICATION?** ☐ Yes ☐ No *If yes, list all and indicate why.*

10. **FAMILY RECORD:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers # _____				
Sisters # _____				

11. **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?** ☐ Yes ☐ No *If yes, indicate type, frequency and date last used.* _____

12. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** ☐ Yes ☐ No *If no, provide complete details.*

13. Do you participate in regular weekly exercise? ☐ Yes ☐ No
14. Do you participate in athletics *(Team or Individual)?* ☐ Yes ☐ No
15. Have you ever used any tobacco products? ☐ Yes ☐ No
16. Do you get regular examinations by your health care provider? ☐ Yes ☐ No
17. Do you get regular annual dental checkups? ☐ Yes ☐ No
18. Do you clean your house or do yard work? ☐ Yes ☐ No
19. Do you have a pet? ☐ Yes ☐ No
20. Are you a member of a social group or volunteer for charity work? ☐ Yes ☐ No

It is represented that the statements and answers given above are true, complete, and correctly recorded. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any health care provider, physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) _____ on _____, _____

Signature of Vendor Representative or Physician

Signature of Proposed Insured

Print name of Proposed Insured

To The Examiner:

File # _____

(Not a Part of the Application for Insurance)

If completed in person, the questions on Pages 1 and 2 must be completed and signed before you.
You must ask the Proposed Insured each question and record the answer.

Questions 21 & 22 For Medical Examiner Use only

Name of Proposed Insured:

_____

Social Security #: _____

Height: _____ Ft. In. Did you measure? _____

Weight: _____ Lbs. Did you weigh? _____

Males Only

A. Chest Expanded _____ In.

B. Chest Contracted _____ In.

C. Abdomen _____ In.

Blood Pressure Obtain 3 Readings

Systolic _____ mm Diastolic _____ mm
Systolic _____ mm Diastolic _____ mm
Systolic _____ mm Diastolic _____ mm

Pulse Rate _____ per minute.

Irregularities ☐ Yes ☐ No Give number per minute _____

Yes No

☐ ☐ Are you in any way related to the Proposed Insured or Insurance Producer? *If yes, give details.*

_____

Yes No

☐ ☐ Was the examination conducted in a language other than English? *If yes, indicate language used and, if applicable, name & relationship of person acting as interpreter.*

_____

_____

Name of Insurance Producer requesting examination:

_____

21. **ANY EVIDENCE OF PAST OR PRESENT MEDICAL CONDITION OR DISORDER OF THE:**

Yes No

☐ ☐ a. Brain, nervous system?
☐ ☐ b. Ears, nose, eyes, throat, teethor gums?
☐ ☐ c. Thyroid or lymph glands?
☐ ☐ d. Heart, blood vessels? *(If yes, complete Question No. 14.)*
☐ ☐ e. Lungs?
☐ ☐ f. Stomach or abdominal organs?
☐ ☐ g. Genito-urinary system?
☐ ☐ h. Skin or extremities?

22. **TO BE COMPLETED IF QUESTION 13d IS ANSWERED YES.**

Yes No

☐ ☐ a. Is there evidence of cardiac enlargement, or abnormal location of the apical impulse (PMI)?
☐ ☐ b. Are there any abnormalities of the first (S1) or second (S2) heart sounds?
☐ ☐ c. Are there gallops (S3 or S4)?
☐ ☐ d. Are there ejection sound(s) or systolic click(s)?
☐ ☐ e. Is/Are there murmur(s) present?

If yes, fully describe under "Details". For murmurs, include timing (systolic or diastolic), intensity (grd. 1-6), location, transmission, radiation.

Details:

INSTRUCTIONS Complete all questions above.

No examiner has any authority to issue a certificate of health or to declare the Proposed Insured acceptable for insurance. Under our rules, only the Company's underwriting department has authority to determine the insurability of the applicants for insurance.

Mail the specimen for laboratory analysis to the laboratory listed on the collection kit or as instructed by your paramedical company.

EXAMINATION WAS MADE AT:

☐ My Office
☐ Residence of Proposed Insured
☐ Place of Business of Proposed Insured.
☐ Other: _____

At _____ AM/PM on _____ , _____

Others present *(indicate None or list name/relationship):*

_____

SIGNATURE OF EXAMINER _____

Print Examiner Name: _____

Company Branch #: _____

Tax Identification Number: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Phone No.: _____

If mailing, send to: Transamerica Life Insurance Company
[4333 Edgewood Road NE
Cedar Rapids, IA 52499
AWD Fax #: 1-800-814-2205]

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

GA # _____

Application Part 2
Non-Medical Health History

File # _____

1. **Proposed Insured:** *(Print Full Name)*	2. **Date of Birth:** Month Day Year	3. **Social Security #**

4. **Name/Address/Phone of primary care physician:**

Name: _____ Address: _____

Phone: _____ City/St/Zip: _____

Date and reason for last visit: _____

5. **Height:** _____ **Weight:** _____

Give complete details of all yes answers to questions 6 - 9, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, attach sheet(s) of paper - **signed, dated and witnessed.**

6. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**	**Yes**	**No**
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	☐	☐
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	☐	☐
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	☐	☐
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	☐	☐
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	☐	☐
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	☐	☐
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	☐	☐
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	☐	☐
i. Cancer, tumor, polyp or cyst?	☐	☐
j. Any physical deformity or amputation?	☐	☐
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	☐	☐
l. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test?	☐	☐

Details:

7.	**Yes**	**No**
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstacy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	☐	☐
b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	☐	☐

8. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:**	**Yes**	**No**
a. Consulted, been examined or been treated by any physician or practitioner?	☐	☐
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study?	☐	☐
c. Had observation or treatment at a clinic, hospital or other medical facility?	☐	☐
d. Had or been advised to have a surgical procedure?	☐	☐
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	☐	☐
f. Had any injury requiring treatment?	☐	☐

File # _____

9.	Yes	No
a. Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide?	☐	☐
b. Has your weight changed by more than 15 pounds in the past year?	☐	☐
c. Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?	☐	☐
d. Are you now pregnant?	☐	☐

10. **OTHER THAN THOSE ALREADY DISCLOSED, ARE YOU CURRENTLY TAKING ANY PRESCRIPTION, VITAMIN, SUPPLEMENT OR OVER-THE-COUNTER MEDICATION?** ☐ Yes ☐ No *If yes, list all and indicate why.*

11. **FAMILY RECORD:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers # _____				
Sisters # _____				

12. **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?** ☐ Yes ☐ No *If yes, indicate type, frequency and date last used.* _____

13. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** ☐ Yes ☐ No *If no, provide complete details.*

14. Do you participate in regular weekly exercise?	☐ Yes	☐ No
15. Do you participate in athletics *(Team or Individual)?*	☐ Yes	☐ No
16. Have you ever used any tobacco products?	☐ Yes	☐ No
17. Do you get regular examinations by your health care provider?	☐ Yes	☐ No
18. Do you get regular annual dental checkups?	☐ Yes	☐ No
19. Do you clean your house or do yard work?	☐ Yes	☐ No
20. Do you have a pet?	☐ Yes	☐ No
21. Are you a member of a social group or volunteer for charity work?	☐ Yes	☐ No

It is represented that the statements and answers given above are true, complete, and correctly recorded. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any health care provider, physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) _____ on _____, _____

AGENT'S STATEMENT: I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Insured.

_____
Signature of Proposed Insured

X _____
Signature of Witness/Agent/Registered Representative

_____
Print name of Proposed Insured

NON-MEDICAL

TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

GA # _____

Life Insurance Application For Two Lives Part 1

Proposed Insured: PI (First, Middle and Last) Title (Mr./Mrs./Ms./Dr.)

Birthdate: _____ Age: _____
Mo. Day Yr.

Birth Place: _____ Male ☐ Female ☐

Soc. Sec. No.: _____

U.S. Citizen ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire

Employer: _____

Occupation: _____

Annual Income $ _____ Net Worth $ _____

Residence: _____
No. & Street (Cannot be a P.O. Box)

City State Zip Country

Area Code & Home Phone Area Code & Work Phone

Additional Proposed Insured: API (First, Middle and Last) Title (Mr./Mrs./Ms./Dr.)

Birthdate: _____ Age: _____
Mo. Day Yr.

Birth Place: _____ Male ☐ Female ☐

Soc. Sec. No.: _____

U.S. Citizen ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire

Employer: _____

Occupation: _____

Annual Income $ _____ Net Worth $ _____

Residence: _____
No. & Street (Cannot be a P.O. Box)

City State Zip Country

Area Code & Home Phone Area Code & Work Phone

Owner's Name: _____ Birthdate: _____
(If other than Proposed Insured and Additional Proposed Insured) Mo. Day Yr.

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured and Additional Proposed Insured: _____

Address: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Soc. Sec. or Tax No.

U.S. Citizen ☐ Yes ☐ No If no, VISA Type/Immigration Status: _____ E-mail: _____
(Not for Policy/Billing Notices)

Beneficiary's Name and Relationship to Proposed Insured: _____

Address: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Date of Trust, if Applicable

1. Plan Applied For: _____ Kind Code: _____
2. Risk Classification: Select ☐ PI ☐ API Preferred ☐ PI ☐ API Standard ☐ PI ☐ API Uninsurable ☐ PI ☐ API
   Extra Rating of _____ ☐ PI _____ ☐ API Other _____ ☐ PI Other _____ ☐ API
3. Nicotine Classification: Non-Nicotine ☐ PI ☐ API Nicotine ☐ PI ☐ API
4. Amount Applied For: $ _____
5. Additional Benefits by Rider: ☐ Estate Protection Rider $ _____ ☐ Other _____ $ _____
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Other _____
   ☐ PAC ☐ Direct Bill
7. Complete For Flexible Premium Plans:
   Required Premium Per Year (RAP) $ _____
   Planned Periodic Premium $ _____
   + Initial Lump Sum $ _____
   = Total Initial Payment $ _____

* D T 0 0 8 *

8. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? ☐ Yes ☐ No
   (APL will be in effect unless no is checked.)
9. Mail Additional Premium Notices To: _____
   Address: _____

Proposed Insured:

10. Do you have any existing life insurance or annuities? If none, check this box. ☐ If yes, please list the policies below.

a. Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? Please indicate yes or no in the chart.

Type of Coverage (Personal/Business/ Employer Provided/Group)	Company/Policy #	Face Amount	Replacement?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

b. Total insurance in force with all companies:
Life Insurance $ _____ Accidental Death $ _____

Yes	No	
☐	☐	11. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? If yes, give insurance company name, owner's name, and amount of insurance of each policy in Remarks.
☐	☐	12. Is any application for life insurance pending with any other company? If yes, give company name, amount applied for and total amount to be placed in Remarks.
☐	☐	13. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
☐	☐	14. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
		15. Have you used nicotine at any time? Date Last Used
☐	☐	Cigarettes _____
☐	☐	Cigar/Pipe/Chewing Tobacco _____
☐	☐	Other _____
		16. Driver's License #: _____ State: _____
		In the past five years, have you been convicted of or pleaded guilty to:
☐	☐	a. Moving violations? If yes, give dates and type.
☐	☐	b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
☐	☐	c. Reckless driving? If yes, give dates. _____
☐	☐	17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
☐	☐	18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
☐	☐	19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
☐	☐	20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

Additional Proposed Insured:

21. Do you have any existing life insurance or annuities? If none, check this box. ☐ If yes, please list the policies below.

a. Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? Please indicate yes or no in the chart.

Type of Coverage (Personal/Business/ Employer Provided/Group)	Company/Policy #	Face Amount	Replacement?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

b. Total insurance in force with all companies:
Life Insurance $ _____ Accidental Death $ _____

Yes	No	
☐	☐	22. Are there any life insurance policies on the life of the Additional Proposed Insured that you do not own, including but not limited to any that you have sold or settled? If yes, give insurance company name, owner's name, and amount of insurance of each policy in Remarks.
☐	☐	23. Is any application for life insurance pending with any other company? If yes, give company name, amount applied for and total amount to be placed in Remarks.
☐	☐	24. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
☐	☐	25. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
		26. Have you used nicotine at any time? Date Last Used
☐	☐	Cigarettes _____
☐	☐	Cigar/Pipe/Chewing Tobacco _____
☐	☐	Other _____
		27. Driver's License #: _____ State: _____
		In the past five years, have you been convicted of or pleaded guilty to:
☐	☐	a. Moving violations? If yes, give dates and type.
☐	☐	b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
☐	☐	c. Reckless driving? If yes, give dates. _____
☐	☐	28. Except as a passenger on a regularly scheduled flight, has the Additional Proposed Insured flown within the past 2 years, or does the Additional Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
☐	☐	29. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
☐	☐	30. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
☐	☐	31. Is the Additional Proposed Insured currently in bankruptcy or has the Additional Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Remarks: Give details for any questions answered yes

_____

_____

_____

_____

The Proposed Insured, the Additional Proposed Insured and the Owner hereby represent that the statements and answers given in this application are true, complete and correctly recorded. **I/We agree:** (1) this application shall consist of Part 1, Part 2 and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (2) no death benefit is payable for a second-to-die or survivorship contract unless both Proposed Insureds die while coverage is in effect; (3) except as otherwise provided in the conditional receipt, if issued, with the same Proposed Insured and Additional Proposed Insured as on this application, any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured and Additional Proposed Insured are in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (4) no waiver or modification shall be binding upon Transamerica Life Insurance Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

I/We understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.

NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to you under Section 101(j) of the Internal Revenue Code to the extent it exceeds the premiums and other considerations paid by you for the policy unless the written Notice and Consent is obtained **prior to policy issue** and certain other requirements of such section are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I/We, the Proposed Insured and the Additional Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the MIB Group, Inc. and its members or affiliates, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; Human Immunodeficiency Virus (HIV) related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me/us and any other non-medical information of me/us to give to the Company or its legal representative, any and all such information.

I/We understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my/our application, claim or as may be otherwise lawfully required or as I/we may authorize.

I/We know that we may each request to receive a copy of this Authorization. I/We agree that a photocopy of this Authorization shall be as valid as the original. I/We agree this Authorization shall be valid for two and one half years from the date shown below, regardless of condition and whether living or not.

I/We acknowledge receipt of the Notice of Disclosure of Information. I/We understand that if an investigative consumer report is ordered in connection with this application, each may elect to be interviewed in connection with the preparation of the report and, upon request, will be provided with a copy of the report. I/we elect to be interviewed if an investigative consumer report is prepared. Proposed Insured ☐ Yes ☐ No Additional Proposed Insured ☐ Yes ☐ No

PLEASE MAKE CHECKS PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE SPACE BLANK.

Amount paid with this Application $ _____ ☐ Check # _____ ☐ Credit Card (Complete Credit Order Confirmation Form)

Signed at _____ on _____ , _____
City - State Date

X _____
Signature of Proposed Insured

X _____
Signature of Additional Proposed Insured

X _____
Signature of Owner (if other than Proposed Insured and Additional Proposed Insured)

X _____
Witness to all signatures

If Owner is a Corporation, an authorized officer, other than the Proposed Insured and Additional Proposed Insured, must sign as owner, give corporate title and full name of corporation below

X _____
Signature of Licensed Producer

_____

_____

_____

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Life Insurance Company (the Company) may make a brief report to the MIB Group, Inc. (MIB) and its members or affiliates, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Notice to Persons Applying for Insurance: Federal law requires us to advise you that in connection with this application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation by your written request made within a reasonable time after receipt of this notice.

Notice of Insurance Information Practices: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499].

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $_____ for the life insurance application dated _____ , with _____ as the Proposed Insured and _____ as the Additional Proposed Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and within the lifetime of the Additional Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

DEATH BENEFIT: No Death Benefit is payable under this Conditional Receipt unless both the Proposed Insured and the Additional Proposed Insured die while any conditional coverage hereunder is in effect. Should only the Proposed Insured or the Additional Proposed Insured (but not both) die from other than suicide or intentional self-inflicted injury while conditional coverage hereunder is in effect, then the second-to-die or survivorship contract applied for will be offered to the joint surviving Proposed Insured or Additional Proposed Insured, providing all conditions of this Receipt have otherwise been met. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $1,000,000 of life insurance if both the Proposed Insured and the Additional Proposed Insured are age 16 - 65 and are both insurable at the standard or better class of risk, $400,000 if either the Proposed Insured or the Additional Proposed Insured is age 66 - 75 and both the Proposed Insured and the Additional Proposed Insured are insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings, including an "Uninsurable" risk classification, regardless of age.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if either the Proposed Insured or the Additional Proposed Insured or both die(s) by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If either Proposed Insured or the Additional Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

X _____ _____ , 20 _____

Signature of Proposed Owner — Date

If Proposed Owner is a Trust, the Trustee must sign as Owner. Give full name and date of Trust below.

If Proposed Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner. Give corporate title and full name of corporation below.

_____ _____

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499], Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

Submit this completed and signed original with the application and payment.

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $_____ for the life insurance application dated _____ , with _____ as the Proposed Insured and _____ as the Additional Proposed Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and within the lifetime of the Additional Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

DEATH BENEFIT: No Death Benefit is payable under this Conditional Receipt unless both the Proposed Insured and the Additional Proposed Insured die while any conditional coverage hereunder is in effect. Should only the Proposed Insured or the Additional Proposed Insured (but not both) die from other than suicide or intentional self-inflicted injury while conditional coverage hereunder is in effect, then the second-to-die or survivorship contract applied for will be offered to the joint surviving Proposed Insured or Additional Proposed Insured, providing all conditions of this Receipt have otherwise been met. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $1,000,000 of life insurance if both the Proposed Insured and the Additional Proposed Insured are age 16 - 65 and are both insurable at the standard or better class of risk, $400,000 if either the Proposed Insured or the Additional Proposed Insured is age 66 - 75 and both the Proposed Insured and the Additional Proposed Insured are insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings, including an "Uninsurable" risk classification, regardless of age.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if either the Proposed Insured or the Additional Proposed Insured or both die(s) by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If either Proposed Insured or the Additional Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at _____ on _____ ,20 _____ X _____
City, State | Date | Insurance Producer or other Company Authorized Rep

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ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499], Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

Leave this page with the proposed Owner if money is submitted with application

Proposed Owner

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

Application Supplement Aviation Questionnaire

Proposed Insured: _____

Social Security No: _____ Date of Birth: _____

1. Indicate flying experience (check all that apply): ☐ Private ☐ Commercial ☐ Military ☐ Pilot ☐ Crew Member ☐ Other _____
2. Current type of aviation certificate: _____
3. Has your certificate ever been suspended or revoked? ☐ Yes ☐ No If yes, give details in Remarks.
4. Current class of medical certificate and expiration date: _____
5. Total hours flown as a pilot in command: _____
6. Do you have an Instrument Flight Rating (IFR)? ☐ Yes ☐ No Number of hours of IFR flying: _____
7. Do you fly outside the U.S.? ☐ Yes ☐ No If yes, give details in Remarks.
8. Have you had any aviation accidents? ☐ Yes ☐ No If yes, give details in Remarks.
9. Have you had any aviation citations? ☐ Yes ☐ No If yes, give details in Remarks.

10. Indicate number of hours flown in each category as a pilot, student pilot, or crew member.

	Type of Flying	Last 12 Months	Last 12-24 Months	Next 12 Months	Date of Last Flight
Private	Student				
	Pleasure or Business				
	Other (Racing, Acrobatic, Stunt, etc. Describe in Remarks.)				
Commercial	Scheduled Passenger Airline (Give employer name in Remarks.)				
	Non-Scheduled Passenger and/or Freight Airline				
	Flight Instruction				
	Corporate Owned Planes for Corporate Business				
	Testing (Describe type of testing and aircraft in Remarks.)				
	Crop-dusting				
	Fire Fighting				
	Other (Describe type in Remarks.)				
Military	Active Duty				
	Reserve Duty				

11. Indicate total hours flown by aircraft type.

Civilian	**Single Engine Airplane**	**Multi Engine Airplane**	**Helicopter**	**Kit or Home Built**	**Other**
Hours flown in Last 12 Months					
Hours to be flown in Next 12 Months					

Military	**Transport**	**Fighter/Bomber**	**Helicopter**	**Carrier Based**	**Proficiency Flying Only, Not Carrier Based**	**Other**
Hours flown in Last 12 Months						
Hours to be flown in Next 12 Months						

Remarks _____

It is represented that the statements and answers given in this supplement to the application are true, complete and correctly recorded. It is agreed that this supplement shall be a part of the application to the Company for insurance on the life of the Proposed Insured.

Signed at _____ on _____

_____ _____

Witness Proposed Insured

AGREEMENT OF OWNER IF OTHER THAN PROPOSED INSURED

The Owner agrees to be bound by all statements, answers, and agreements made by the Proposed Insured in this supplement to the application. If the Owner is a corporation, an authorized officer, other than the Proposed Insured, must sign as Owner, giving corporate title and full name of corporation.

Signed at _____ on _____

_____ _____

Witness Owner

Corporate Title: _____ Corporation Name: _____

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

Application Supplement
Sports and Hazardous Activities Questionnaire

Proposed Insured: _____

Social Security No: _____ Date of Birth: _____

DT046

Please answer each question.

1. **Scuba Diving**
   ☐ No, I do not participate. ☐ Yes, I do participate.
   Number of times per year: _____ Locations of activity: _____
   Type of equipment used: _____
   Depth in feet: Average _____ Maximum _____ Number of times per year to Maximum depth? _____
   How will your participation change in the next 24 months? _____
2. **Aeronautics.** Includes hang-gliding, soaring, sky diving, ballooning, ultralight flying, parachuting, etc.
   ☐ No, I do not participate. ☐ Yes, I do participate in: _____
   Number of times per year: _____
   Locations of activity: _____
   Type of equipment used: _____
   Do you belong to a club or association? ☐ Yes ☐ No If yes, give name: _____
   How will your participation change in the next 24 months? _____
3. **Powered racing or competitive vehicles.** Includes motorcycles/ATV's, automobiles/cart racing, powerboats, snowmobiling, etc.
   ☐ No, I do not participate. ☐ Yes, I do participate in: _____
   Number of times per year: _____ Locations of activity: _____
   Racing Classification: _____
   Type and description of vehicle used: _____
   Describe race and track: _____
   _____
   Attained speeds: Maximum _____ Average _____
   How will your participation change in the next 24 months? _____
4. **Mountain or Rock Climbing**
   ☐ No, I do not participate. ☐ Yes, I do participate in: _____
   Number of times per year: _____ Locations of activity: _____
   _____
   Rock Climbing Classification: _____
   What type of equipment is used: _____
   Do you participate in ice and snow climbing? ☐ Yes ☐ No
   How will your participation change in the next 24 months? _____
5. **Rodeos, Competitive Skiing or Snowboarding**
   ☐ No, I do not participate. ☐ Yes, I do participate in: _____
   Number of times per year: _____ Locations of activity: _____
   Describe activities: _____
   _____
   How will your participation change in the next 24 months? _____
6. **Any Other Extreme Sports or Hazardous Activities**
   ☐ No, I do not participate. ☐ Yes, I do participate in: _____
   Number of times per year: _____ Locations of activity: _____
   Describe activities: _____
   _____
   How will your participation change in the next 24 months? _____

It is represented that the statements and answers given in this supplement to the application are true, complete and correctly recorded. It is agreed that this supplement shall be a part of the application to the Company for insurance on the life of the Proposed Insured.

Signed at _____ on _____

_____ Witness

_____ Proposed Insured

AGREEMENT OF OWNER IF OTHER THAN PROPOSED INSURED

The Owner agrees to be bound by all statements, answers, and agreements made by the Proposed Insured in this supplement to the application. If the Owner is a corporation, an authorized officer, other than the Proposed Insured, must sign as Owner, giving corporate title and full name of corporation.

Signed at _____ on _____

_____ Witness

_____ Owner

Corporate Title: _____ Corporation Name: _____

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

Application Supplement Residency & Travel Questionnaire

1. Proposed Insured: _____ 2.Social Security No.: _____
3. Date of Entry to USA: _____ 4.Place of Birth: _____ 5. Date of Birth: _____
6. Country of Citizenship _____ (if U.S. Citizen, skip to 12.)
7. Do you possess an Alien Registration Receipt, "Green Card"? ☐ Yes ☐ No
8. Type of Visa (see listing of Visa types): _____
9. Visa Expiration Date: _____
10. Do you own assets or property outside the U.S.? (List) _____
    _____
11. Do you own assets or property inside the U.S.? (List) _____
    _____
12. Length of time with present employer: _____
13. Do you plan to travel or reside outside of the U.S.? ☐ Yes ☐ No
    If yes, please provide details.

	Next 12 Months
Destination(s)	
Date(s)	
Duration of Stay	
How Often	

14.Remarks: _____
_____
_____

Visa Types

A:	Government Official	**I:**	Information Media Rep.
B1:	Visitor/Business	**J:**	USIA Education/Cultural Exchange
B2:	Visitor/Medical Treatment	**K1:**	Fiancée/Fiancé
C:	Transit	**L:**	Intra-Company Transfer
D:	Crewman	**M:**	Vocational/Non-Academic Studies
E1:	Treaty Trader	**O1-2:**	Science/Art
E2:	Treaty Investor	**P1-3:**	Athletes, Artists, Entertainers
E3-5:	Misc. Employment Visas	**Q1:**	INS Int'l Cultural Exchange
F1-4:	Family Based/Academic Studies	**R:**	Non-Immigrant Religious
G:	Representative to International Organization	**SB-1:**	Returning Resident Alien
H1-B:	Temporary Worker - Distinguished Merit/Ability	**SD:**	Immigrant - Religious
H-2A/B:	Temporary Worker - General Labor	**TN:**	NAFTA Professionals
H-3:	Temporary Worker - Trainee	Other Category:	_____

It is represented that the statements and answers given in this supplement to the application are true, complete and correctly recorded. It is agreed that this supplement shall be a part of the application to the Company for insurance on the life of the Proposed Insured.

Signed at _____ on _____

_____ Witness

_____ Proposed Insured

AGREEMENT OF OWNER IF OTHER THAN PROPOSED INSURED

The Owner agrees to be bound by all statements, answers, and agreements made by the Proposed Insured in this supplement to the application. If the Owner is a corporation, an authorized officer, other than the Proposed Insured, must sign as Owner, giving corporate title and full name of corporation.

Signed at _____ on _____

_____ Witness

_____ Owner

Corporate Title: _____ Corporation Name: _____

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
Company Tracking Number:	*TRANS APA401008T APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
Company Tracking Number:	*TRANS APA401008T APPL*		
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Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 05/29/2008

Comments:

Attachment:

AR_AR Certif of Compliance with Rule 19.pdf

Review Status:

Satisfied -Name: Application 05/29/2008

Comments:

This is an application only submission.the forms are new.

Review Status:

Bypassed -Name: Health - Actuarial Justification 05/29/2008

Bypass Reason: This is an application only submission.

Comments:

Review Status:

Bypassed -Name: Outline of Coverage 05/29/2008

Bypass Reason: This is an application only submission.

Comments:

Review Status:

Satisfied -Name: Readability Certification 05/29/2008

Comments:

Attachment:

Readability Transamerica Life Insurance Company.pdf

Review Status:

Satisfied -Name: Filing Authorization 05/29/2008

Comments:

Attachment:

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
Company Tracking Number:	*TRANS APA401008T APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

CRS Letter of Auth - TLIC 5-22-08.pdf

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
Company Tracking Number:	*TRANS APA401008T APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Review Status:

Satisfied -Name: Statement of Variables 05/29/2008

Comments:

Attachment:

Transamerica Application - Statement of Variability.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: **Transamerica Life Insurance Company**

Form Number(s): Form APA401008T, Individual Life Application for One Life
Form MPM31008T, Application Part 2, Medical and Paramedical Health History
Form MPN11008T, Application Part 2, Non-Med Health History
Form APA411008T, Life Insurance Application for Two Lives
Form MPQ21008T, Application Supplement, Aviation Questionnaire
Form MPQ151008T, Application Supplement, Sports and Hazardous Activities Questionnaire
Form MPQ161008T, Application Supplement, Residency and Travel Questionnaire

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Cheryl Bock
Name

Assistant Vice President, Director
Product Implementation
Title

5-29-2008
Date

Transamerica Life Insurance Company

New – Application form filing

READABILITY CERTIFICATION

This is to certify that the form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

	Score
APA 40-1008 Application for One Life	50.3
MPM 3-1008 Medical/Paramedical Application	55.2
MPN 1-1008 Non-Med Application	55.4
APA 41-1008 Two Life Application	50.3
MPQ 2-1008 Aviation Questionnaire	56.1
MPQ 15-1008 Sports and Hazardous Act. Questionnaire	50.8
MPQ 16-1008 Residency and Travel Questionnaire	55.7

Assistant Vice President, Director,
Product Implementation
319-355-4240

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
4333 Edgewood Road NE
PO Box 3183
Cedar Rapids, Iowa 52499

May 22, 2008

NAIC Company Code: 468-86231

Re: Individual Life Insurance Applications

To: All Departments of Insurance

Transamerica Life Insurance Company hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

Cheryl Bock

Cheryl Bock
Assistant Vice President, Contract Development

Statement of Variability
Transamerica Life Insurance Company

NAIC #86231-468 FEIN #39-0989781

Forms:

Form APA401008T, Individual Life Application for One Life
Form MPM31008T, Application Part 2, Medical and Paramedical Health History
Form MPN11008T, Application Part 2, Non-Med Health History
Form APA411008T, Life Insurance Application for Two Lives
Form MPQ21008T, Application Supplement, Aviation Questionnaire
Form MPQ151008T, Application Supplement, Sports and Hazardous Activities Questionnaire
Form MPQ161008T, Application Supplement, Residency and Travel Questionnaire

The only variable text in these forms is the company address (4333 Edgewood Road, N.E. Cedar Rapids, Iowa 52499). The bracketed address appears in the forms as follows:

APA401008T & APA411008T—Page 1 header; Paragraph 4 of the Notice of Disclosure of Information; Last Paragraph of the acknowledgment of the Conditional Receipt (on each of the last two pages of the applications)
MPM31008T—Page 1 header; Page 3 last paragraph.
MPN11008T—Page 1 header.
MPQ21008T, MPQ151008T & MPQ161008T—Page 1 header.

The reason for this variability is to accommodate any possible future address changes without requiring refiling of the forms.

SERFF Tracking Number:	*CMPL-125670265*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39123*
Company Tracking Number:	*TRANS APA401008T APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans APA401008T APPL*		
Project Name/Number:	*Trans APA401008T APPL/Trans APA401008T APPL*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Application Supplement, Residency and Travel Questionnaire	05/29/2008	MPQ161008T Standard.pdf

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

Application Supplement Residency & Travel Questionnaire

1. Proposed Insured: _____ 2.Social Security No.: _____
3. Date of Entry to USA: _____ 4.Place of Birth: _____ 5. Date of Birth: _____
6. Country of Citizenship _____ (if U.S. Citizen, skip to 12.)
7. Do you possess an Alien Registration Receipt, "Green Card"? ☐ Yes ☐ No
8. Type of Visa (see listing of Visa types): _____
9. Visa Expiration Date: _____
10. Do you own assets or property outside the U.S.? (List) _____
    _____
11. Do you own assets or property inside the U.S.? (List) _____
    _____
12. Length of time with present employer: _____
13. Do you plan to travel or reside outside of the U.S.? ☐ Yes ☐ No
    If yes, please provide details.

	Next 12 Months
Destination(s)	
Date(s)	
Duration of Stay	
How Often	

14.Remarks: _____
_____
_____

Visa Types

A:	Government Official	**I:**	Information Media Rep.
B1:	Visitor/Business	**J:**	USIA Education/Cultural Exchange
B2:	Visitor/Medical Treatment	**K1:**	Fiancée/Fiancé
C:	Transit	**L:**	Intra-Company Transfer
D:	Crewman	**M:**	Vocational/Non-Academic Studies
E1:	Treaty Trader	**O1-2:**	Science/Art
E2:	Treaty Investor	**P1-3:**	Athletes, Artists, Entertainers
E3-5:	Misc. Employment Visas	**Q1:**	INS Int'l Cultural Exchange
F1-4:	Family Based/Academic Studies	**R:**	Non-Immigrant Religious
G:	Representative to International Organization	**SB-1:**	Returning Resident Alien
H1-B:	Temporary Worker - Distinguished Merit/Ability	**SD:**	Immigrant - Religious
H-2A/B:	Temporary Worker - General Labor	**TN:**	NAFTA Professionals
H-3:	Temporary Worker - Trainee	Other Category:	_____

It is represented that the statements and answers given in this supplement to the application are true, complete and correctly recorded. It is agreed that this supplement shall be a part of the application to the Company for insurance on the life of the Proposed Insured.

Signed at _____ on _____

_____ Witness

_____ Proposed Insured

AGREEMENT OF OWNER IF OTHER THAN PROPOSED INSURED

The Owner agrees to be bound by all statements, answers, and agreements made by the Proposed Insured in this supplement to the application. If the Owner is a corporation, an authorized officer, other than the Proposed Insured, must sign as Owner, giving corporate title and full name of corporation.

Signed at _____ on _____

_____ Witness

_____ Owner

Corporate Title: _____ Corporation Name: _____